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Women's experiences of managing digitation: do we ask enough in primary care?

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Summary

The aim of this paper was to consider the available evidence for the current management of pelvic organ prolapse, which is a common presentation in primary care. However, not all women will present, only presenting when symptoms become bothersome. Particular attention was paid to understanding the problem of rectocele and its influence on obstructive defaecation symptoms. The burden of rectocele and its consequences are not truly known. Furthermore, healthcare professionals may not always enquire about bowel symptoms and patients may not disclose them. Complex emotions around coping and managing stress add to the challenges with seeking healthcare. Therefore, the impact on the lived experience of women who have difficulty with rectal emptying can be significant. The review identified a dearth of knowledge about women living with the problem of obstructive defaecation resulting in the use of digitation. Improving the management of digitation, an under-reported problem, is necessary to improve the quality of life for women. Primary care needs to increase access to conservative measures for women struggling with bothersome symptoms, such as constipation, the need to digitate or anxiety.

Keywords

difficulty emptying, digitation, rectocele, obstructive defaecation, pelvic organ prolapse, primary care

Introduction

Pelvic organ prolapse is, for many women, a distressing long-term condition.[1,2] The prevalence of all prolapse is around 40% for women over 50 years of age, which equates to 4.6 million women across the UK.[3–5] Risk factors are known to be multiparity, ageing and obesity, but little is known about the histological cause.[6] Women can suffer in silence and only present to primary care when prolapse and associated symptoms are becoming increasingly bothersome, and may experience anxiety and depression.[7] One associated symptom is the need to digitally re-position the anatomy with their fingers to align the rectum for passing stool, which can lead to poor quality of life.[8] A recent study identified that 56% of women with rectocele reported the need to use digitation to aid rectal emptying.[9] This paper considers the available evidence for the current management of pelvic organ prolapse, understanding the extent of the problem with particular attention to rectocele, which can cause obstructive defaecation symptoms, the lived experience of women who have difficulty with rectal emptying and improving the management of digitation.

Methods

A literature review was conducted using the search terms difficulty emptying, digitation, rectocele, obstructive defaecation, pelvic organ prolapse and primary care. Medline, CINAHL, PsychInfo, Embase and Google Scholar were the main databases for searching as well as hand searches from year 1995 to present day (Appendix 1 offers an example search). Most of the identified literature focused on surgery for pelvic organ prolapse, which were rejected. Given the limited attention to the lived experience, all identified papers were included.

Current management of pelvic organ prolapse

Pelvic organ prolapse is more common in parous women,[2] and can occur in any of the three vaginal compartments (anterior, apical or posterior). Of these women, only up to 20% may head towards healthcare,[10] usually when symptoms become bothersome. Latest evidence supports the need to focus on conservative measures before advancing to a surgical intervention,[11] such as the prevention of constipation,[12] which has been associated with prolapse symptoms.

Conservative measures aim to focus on preventing the prolapse from getting worse by reducing frequency or severity of symptoms and delaying the need for surgery.[13] Two particular interventions that primary care can advise/offer is pelvic floor muscle exercises and vaginal pessaries. Pelvic floor muscle training is a safe and cost-effective intervention for reducing the severity of prolapse symptoms, supported by robust clinical trials.[14,15] Furthermore, the use of a pessary to provide structural support offers a viable management option. Pessary choice is based on clinical experience; alongside trial and evaluation, mainly because there is minimal evidence on specific pessaries for specific prolapse types.[16] Different factors influence the duration of pessary use, in particular the use of vaginal oestrogens.[17]

Current healthcare management of pelvic organ prolapse should ideally begin in primary care. Evidence of what interventions may work before heading to surgery is increasing, although there remain major gaps in our knowledge (Box 1). Symptomatic prolapse that, for some women, does not respond to conservative measures may well require secondary care referral. Surgical intervention has been fraught with challenges, for example, defining successful outcome (anatomic or symptomatic) or justifying the use of mesh.[18] However, measurement of improvement has progressed, which now includes measuring outcomes for anatomy, symptoms, quality of life and risk of reoperation.[19]

Understanding the extent of the problem

Searching and reviewing the literature identified the gaps in understanding the extent of the problem, particularly when seeking to understand obstructive defaecation symptoms as a result of rectocele. However, the available literature provided insight into the necessity to offer conservative measures for women, especially regarding bothersome symptoms prior to any surgery. The health seeking behaviour of women with prolapse can be low.[20] Yet, they may initially present to primary care with associated symptoms such as constipation. Constipation in women is four times more associated with a defaecatory disorder than in men and often not asked about.[21] Self-management options used by women are poorly understood and healthcare falls short of discovering the impact of these on their quality of life.

Bowel problems in women can be caused by posterior vaginal compartment prolapse, leading to obstructive defaecation, which is defined as incomplete evacuation of stool from the rectum.[22] A common feature of obstructive defaecation is a posterior vaginal wall bulge called a rectocele,[23] with symptoms of incomplete emptying, straining, digitation or splinting.[1,22] Digitation or splinting tends to be a self-initiated procedure[24] often adopted by women when experiencing difficulty emptying their rectum. Digitation can feel undignified for many women, which involves using fingers within the vagina or via the rectum to evacuate stool. Splinting is defined as the women's own fingers being placed on the perineum or buttocks to aid defaecation.[22] Awareness of this common problem in primary care as well as secondary care is variable.[25]

Knowledge of posterior compartment prolapse aetiology and its relationship to symptoms is increasingly recognised as lacking and, at times, controversial.[26,27] Patient exposure to surgical options when we do not really know if it is the best option requires better understanding. However, Guzman Rojas et al.[26] suggest that there may be some inconsistency with aetiology and symptoms. They studied datasets from 719 women retrospectively, who had undergone transperineal ultrasound, which evaluates the anatomy, or a traditional clinical examination. The findings indicate that transperineal ultrasound is superior to traditional clinical examination for comprehensively correlating anatomy with symptoms. Access to investigation such as transperineal ultrasound is sparse and therefore many primary and secondary care settings will not have facilities to improve diagnosis, so whilst this study is shedding light, diagnostic abilities will be limited in the real world. Many clinicians in primary care rely on taking a good history with or without clinical examination to yield information based on the patient's presentation. The emerging idea that traditional clinical examination may be

Box 1. Current evidence of pelvic organ prolapse.

What we know	What we do not know
• Constipation can impact on prolapse symptoms • Pelvic floor muscle exercises are a cost-effective and safe intervention • Vaginal support pessaries may help resolve symptoms and delay the need for surgery	• Risk factors for recurrent prolapse • Impact of lifestyle interventions • Impact of prolapse surgery on bladder health

inferior could lead to sub-optimal conservative treatment, especially if not offered at all. Maximising treatment options across all settings draws on the role of shared decision-making, thus offering a cornerstone in making this a reality.

Conservative measures initiated as first line might receive better attention in a shared decision-making consultation. Shared decision-making has been gathering pace politically as a cornerstone to involving the patient in their care and as a lever to improve quality and safety. However, embedding this into practice can be haphazard, is untaught, hard to do and evaluate. The lack of evidence to support effective approaches to shared decision-making has been portrayed by a Cochrane systematic review,[28] which identifies the need for further research in this area. To compensate, aspirational documents have offered guidance on shared decision-making,[29,30] but are weak on how to do it effectively. In practice, the informed patient may be more likely to help foster shared decision-making, otherwise poor communication and lack of engagement between the patient and healthcare professional could encourage disempowerment. Women presenting with embarrassment about their bowel condition may not be informed about what options are available to help them, mainly because they have been coping and managing their problem in secret. Consultations that lack a shared decision-making approach may leave the woman reluctant to bother the healthcare professional again and further disengage them from seeking help.

Healthcare professionals may not always enquire about bowel symptoms and patients may not disclose them. Therefore, asking about bowel concerns and how they manage it may reveal distress and a lead to proactive measures. For example, in a cross-section survey study of 172 women attending a urogynaecology clinic, Bezerra et al.[8] identified lower quality of life in those with unreported bowel symptoms. Furthermore, Guzman Rojas et al.[26] emphasises the necessity for active patient questioning because of the high prevalence of symptoms. Commonly, women find ways to manage by using their own fingers to add pressure to the perineum or insert them into the vagina or rectum.[26] If ineffective, the constant feeling of needing to defaecate can lead to numerous toilet visits, and become burdensome. Interestingly, Hai-Ying et al.[24] detected in their retrospective study of 271 women that the method of digitation used was not discernible in terms of bother and all were associated with obstructive defaecation symptoms.[24]

Conservative measures should be offered and reviewed in primary care before onward referral, while sensitively taking into account the individual preferences.[31,32] Primary care can be proactive in offering conservative measures.

However, it is not clear what proportion of women is managed conservatively in primary care before onward referral to secondary care.[33,34] Delays in self-reporting can be up to 41 months and it has been reported that primary care may be responsible for 33.5% of delay in treatment.[35] Treatment approaches, for example, include pelvic floor muscle exercises for symptomatic mild prolapse.[36] Panman et al.[36] identified in a randomised controlled trial of 287 women over 55 years that intervention with pelvic floor muscle exercises was better at improving symptoms than watchful waiting. However, there is an unfamiliarity in primary care with pelvic floor disorders compared to bladder conditions.[37] Unfamiliarity may lead to an underestimation of the problem. Therefore, raising awareness can facilitate asking the right questions, early assessment and treatment. Awareness can yield an opportunity to delay surgical intervention, or avoid it altogether. Reducing inappropriate referrals to secondary care is a cornerstone of current National Health Service policy and innovative ways of developing and delivering care can facilitate this.[38] In a prospective evaluation by Hicks et al.[31] on 90 women with obstructive defaecation and rectocele who were treated conservatively, 71.1% improved their symptoms. Whilst the results are encouraging, there needs to be clear information available to healthcare professionals and patients of what options are available, underpinned by available best evidence.

Lived experience of women who have difficulty with rectal emptying

Rectocele burden and its consequences are not truly known.[23] Much of the literature presents on surgical approaches for posterior compartment prolapses, of which rectocele is one. Understanding the psychological impact of living with obstructive defaecation and its consequences is lacking in the literature. Low self-esteem issues can be identified during clinical consultations. Despite the lack of literature, there is increasing understanding of how bowel problems can affect quality of life,[39] especially with regard to body image[40] and activities of daily living.[41] Our relationship with personal bowel function is mainly a private affair and for some it takes courage to raise these issues with healthcare professionals. Fear and shame may possibly lead women to finding intuitive ways to manage their problem.

Complex emotions around coping and managing stress add to the challenges with seeking healthcare. Living with a problem such as obstructive defaecation

receives inadequate focus in the literature.[42] Feelings of isolation and perceptions of being the only one with the problem may create barriers to self-fulfilment and treatment opportunities, which can be identified in clinical care. Women may maintain a healthcare problem in secret, which society tends to perpetuate with a culture of perfection being an aspiration. Even so, there is a general unease across populations to talk about personal bodily functions.[43]

Promoting bowel care as an important subject and reducing stigma in healthcare has received minimal attention until more recently.[44,45] Embarrassing health problems can lead many people to feel marginalised. It is not clear if women in these circumstances can be classified as hard to reach.[46] The work of Flanagan and Hancock[46] contributes a useful interpretation on the 'hard to reach' and suggests how the National Health Service can improve access by addressing attitudes, flexibility of service, good engagement and partnership working. Developing a deeper understanding of the problem facing women with obstructive defaecation, the emergence of innovation has potential.

Improving the management of digitation

The spread and adoption of new ways of delivering care through innovation can be a stimulating prospect. Innovation in the field of prolapse management has mainly seen a plethora of surgical inserts to support weakness in the anatomical structures. Current interventions that have been better studied are from the surgical prospective.[47,48] However, non-surgical devices have not received the same attention and therefore the intuitive approaches that women adopt tend to dominate. Production of novel non-surgical conservative devices has been deficient, most probably because of it being a hidden topic. However, when considering an invention of a patient-centred device in this area, identifying the strengths, opportunities, weaknesses and threats can assist with the innovation journey (Box 2).

For some women, digitation can be an unpleasant process and it requires good dexterity, which poses added problems with co-morbidities or increasing age. The means by which women navigate to digitation without being taught or told how to do it is particularly interesting. This development of self-knowledge is intriguing in that instinctively women decide that something (i.e. digitation) might work. Digitation does not work for all women, but the intention appears to be present. How this manifests emotionally for the woman is scarcely addressed.[49] The potential for innovation in this area may exist, especially with regard to enabling women to manage digitation more easily, which may help improve self-confidence and quality of life, and additionally contribute to conservative options via clinical care pathways.

Box 2. SWOT for innovating a patient-centred device.

Strengths	Opportunities
• Increase self-confidence • Improve rectal emptying • Delay surgical intervention	• Delay referrals into secondary care • Additional option for conservative management
Weaknesses	**Threats**
• Unknown impact on care as no similar patient-centred device available	• Not acceptable to women • Does not work as intended

Conclusion

This review considered the available evidence for the current management of pelvic organ prolapse, understanding the extent of the problem with particular attention to rectocele, and the lived experience of women who have difficulty with rectal emptying, whilst taking into account the need to improve the management of digitation. The findings help to stimulate a conversation on when and how to use a conservative management approach for women with pelvic organ prolapse. We have identified a dearth of knowledge about women living with the problem of obstructive defaecation leading them to use digitation. However, there is a promising opportunity for healthcare professionals in primary care to improve the experience of women struggling with bothersome symptoms, such as constipation, the need to digitate or anxiety. Further research is recommended that takes a deeper look into the lived experiences of women who struggle with symptoms.

Declarations

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Appendix 1

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Search History

1. PsycInfo; (obstructive AND defaecation).ti,ab; 1 results.
2. PsycInfo; rectocele.ti,ab; 6 results.
3. PsycInfo; depression.ti,ab; 191498 results.
4. PsycInfo; anxiety.ti,ab; 150630 results.
5. PsycInfo; 1 AND 2; 0 results.
6. PsycInfo; 2 AND 3; 0 results.
7. PsycInfo; 2 AND 4; 0 results.
8. PsycInfo; constipation.ti,ab; 1496 results.
9. PsycInfo; 3 AND 8; 328 results.
10. PsycInfo; 2 AND 3 AND 8; 0 results.
11. PsycInfo; female.ti,ab; 207298 results.
12. PsycInfo; 3 AND 8 AND 11; 12 results.
13. PsycInfo; (difficulty AND emptying).ti,ab; 9 results.
14. PsycInfo; "difficulty emptying".ti,ab; 2 results.
15. PsycInfo; 4 AND 8 AND 11; 9 results.
16. CINAHL; (obstructive AND defaecation).ti,ab; 3 results.
17. CINAHL; rectocele.ti,ab; 48 results.
18. CINAHL; depression.ti,ab; 45970 results.
19. CINAHL; anxiety.ti,ab; 27699 results.
20. CINAHL; 16 AND 17; 1 results.
21. CINAHL; 17 AND 18; 0 results.
22. CINAHL; 17 AND 19; 0 results.
23. CINAHL; constipation.ti,ab; 2945 results.
24. CINAHL; 18 AND 23; 172 results.
25. CINAHL; 17 AND 18 AND 23; 0 results.
26. CINAHL; female.ti,ab; 63228 results.
27. CINAHL; 18 AND 23 AND 26; 11 results.
28. CINAHL; (difficulty AND emptying).ti,ab; 27 results.
29. CINAHL; "difficulty emptying".ti,ab; 3 results.
30. CINAHL; 19 AND 23 AND 26; 10 results.
31. CINAHL; 17 AND 29; 0 results.
32. CINAHL; 17 AND 18; 0 results.
33. CINAHL; "obstructive defaecation".ti,ab; 0 results.
34. CINAHL; "obstructive defecation".ti,ab; 5 results.
35. CINAHL; 23 AND 34; 0 results.
36. BNI; (obstructive AND defaecation).ti,ab; 0 results.
37. BNI; rectocele.ti,ab; 1 results.
38. BNI; depression.ti,ab; 6930 results.
39. BNI; anxiety.ti,ab; 4340 results.
40. BNI; 36 AND 37; 0 results.
41. BNI; 37 AND 38; 0 results.
42. BNI; 37 AND 39; 0 results.
43. BNI; constipation.ti,ab; 604 results.
44. BNI; 38 AND 43; 30 results.
45. BNI; 37 AND 38 AND 43; 0 results.
46. BNI; female.ti,ab; 2906 results.
47. BNI; 38 AND 43 AND 46; 2 results.
48. BNI; (difficulty AND emptying).ti,ab; 2 results.
49. BNI; "difficulty emptying".ti,ab; 1 results.
50. BNI; 39 AND 43 AND 46; 3 results.
51. BNI; (obstructive AND defaecation).ti,ab; 0 results.
52. BNI; rectocele.ti,ab; 1 results.
53. BNI; depression.ti,ab; 6930 results.
54. BNI; anxiety.ti,ab; 4340 results.
55. BNI; 51 AND 52; 0 results.
56. BNI; 52 AND 53; 0 results.
57. BNI; 52 AND 54; 0 results.
58. BNI; constipation.ti,ab; 604 results.
59. BNI; 53 AND 58; 30 results.

Page 3